



CITY OF SAN ANTONIO

Human Resources Department

P. O. BOX 839966
SAN ANTONIO TEXAS 78283-3966

October 17, 2011

Subject: Domestic Partner Information and Enrollment Packet

Dear Employee/Retiree:

I am pleased to announce that beginning January 1, 2012, the City of San Antonio will extend medical and voluntary dental/vision/life benefits to same and opposite gender domestic partners. Extending such benefits to domestic partners supports the City's efforts to become an employer of choice; become more competitive in the public and private sectors of the market regarding recruitment and retention of great talent; promote workplace diversity, and improve employee satisfaction and morale.

The attached domestic partner information and enrollment packet has been designed to provide you with the enrollment guidelines and tax considerations you should be aware of when determining your domestic partner's and/or his/her dependent child(ren)'s eligibility for health, dental, vision, and life insurance coverage, and the impact their enrollment will have on your tax status. Please note that the information regarding tax implications is not intended as tax advice. You are encouraged to seek the guidance of your personal tax advisor regarding income tax implications and before certifying that your domestic partner and/or his/her child(ren) qualify as dependents, as defined by the Internal Revenue Code.

To assist you with this new enrollment process, the following items are included within this packet:

- Domestic Partnership Affidavit and Agreement
- Taxable Income and Incremental Costs
- Domestic Partnership Tax Dependent Status Form
- Benefits Enrollment Form

Please submit the required Domestic Partnership Affidavit and Agreement, Domestic Partnership Tax Dependent Status Form, and Benefits Enrollment Form, with the necessary supporting documentation, to the Human Resources Department – Employee Benefits Division at 115 Plaza de Armas, Suite 260, San Antonio, Texas 78285. If you have any questions or need assistance, contact the Employee Benefits Division at 210-207-0073.

Sincerely,

A handwritten signature in blue ink, appearing to read "Patricia Atkins".

Patricia Atkins
Employee Benefits Administrator
Employee Benefits Division



CITY OF SAN ANTONIO

Human Resources Department

P. O. BOX 839966
SAN ANTONIO TEXAS 78283-3966

DOMESTIC PARTNERSHIP AFFIDAVIT AND AGREEMENT

We, _____, and _____
Print Full Name of Employee/Retiree Print Full Name of Domestic Partner

Swear and affirm that we are domestic partners according to the following definition contained in the City of San Antonio Policies:

Domestic Partner is a committed relationship between two adults, which meets all of the following conditions:

- The domestic partnership has been in effect for at least 6 months;
- Both partners are at least eighteen years of age;
- Both partners are each other's sole domestic partner and intended to remain so indefinitely as attested to in the affidavit;
- Neither partner is married (either legally or by common law) to, legally separated from, anyone else;
- The partners are not related by blood or marriage to a degree of closeness that would prohibit marriage in the state in which they reside;
- Both partners agree they are in committed relationship and consider each other jointly responsible for each other's common welfare and financial obligations; and
- Both partners agree that they are not in the relationship solely for the purpose of obtaining benefits coverage.

We understand that the City may ask us to produce documentation or other proof that we meet or continue to meet the above definition and we agree to provide such documentation or proof.

We agree that if our relationship changes so that we no longer meet the above definition, the Employee/Retiree will provide written notice of that change to Benefits Division of the City of San Antonio Human Resources Department within thirty-one (31) days of the date of change.

This Affidavit and Agreement is submitted to the City of San Antonio specifically to qualify the Domestic Partner for coverage under the medical and/or dental plans offered by the City of San Antonio with the understanding that the eligibility of the Domestic Partner for such benefits depends on the truthfulness of our statements in this Affidavit. We understand that knowingly providing misinformation in this document will result in disciplinary action against the Employee, and the City may recover from either or both the Employee/Retiree and the Domestic Partner, all costs incurred by the City related to benefit coverage for the Domestic Partner.

Each of us swear and affirm that we have read this document, that the statements herein are true and correct, that we understand the content and important of the agreements herein, and that, in considerations of the City's provision of benefit coverage for the Domestic Partner, we agree to abide by the provisions of this Affidavit and Agreement.

Employee/Retiree Signature

Date

Employee/Retiree Social Security Number

Domestic Partner Sign

Date

Domestic Partner Social Security Number

2012 Domestic Partner Medical Coverage Taxable Income and Incremental Costs

Employees applying for domestic partner benefits should be aware that such benefits have significant tax consequences. This statement is not intended as tax or legal advice but rather to alert employees of the potential tax ramifications.

You and the City of San Antonio share in the cost of covering a domestic partner and/or his/her eligible dependent children, the same as someone would for coverage of a spouse and their own eligible dependent children. However, there are additional financial and tax implications to consider with a domestic partner. The Internal Revenue Service (IRS) has determined that an employer's cost of providing benefits for a domestic partner and their children is considered "imputed income", which means it is subject to taxes.

The City must report on your W-2 form the fair market value of an employee's domestic partner benefits as wages or "imputed income" to the IRS, resulting in increased taxable gross income for federal income taxes. In addition, FICA (Social Security and Medicare) taxes will be withheld from your paycheck. The amount of this income depends upon the plan in which you are enrolled and the level of coverage.

The following is an example of the taxability of coverage if you are enrolled in the Value Plan and were hired before January 1, 2009. The payroll deduction amount to cover your domestic partner and/or your partner's child is a post tax deduction, unlike medical coverage for the enrolled family members.

Level of Coverage Under Value Plan - Pre-2009 Hire	Total Employee Deduction	EE Deduction portion that is Pre-Tax	EE Deduction Portion that is Post-Tax	Imputed Income*
Employee + Domestic Partner	\$36.00	\$3.50	\$32.50	\$64.58
Employee + Domestic Partner + Domestic Partner Child	\$46.00	\$3.50	\$42.50	\$127.17
Employee + Employee Child + Domestic Partner	\$46.00	\$9.00	\$37.00	\$60.08
Employee + Employee Child + Domestic Partner + Domestic Partner Child	\$46.00	\$3.50	\$42.50	\$127.17
Employee + Employee Child + Domestic Partner Child	\$9.00	\$3.50	\$5.50	\$67.10
Employee + Domestic Partner Child	\$9.00	\$3.50	\$5.50	\$67.10
Employee + Certified Domestic Partner** + Domestic Partner Child	\$46.00	\$36.00	\$10.00	\$62.60
Employee + Domestic Partner + Certified Domestic Partner Child** + Employee Child	\$46.00	\$9.00	\$37.00	\$60.08
Employee + Certified Domestic Partner** + Domestic Partner Child + Employee Child	\$46.00	\$36.00	\$10.00	\$62.60

***Imputed Income** – Income separate from, and in addition to, your monthly plan cost. It is the City's contribution toward the additional coverage for your domestic partner and/or your partner's child. The imputed income is subject to federal tax withholding, Social Security tax and Medicare tax.

****Certified Domestic Partner or Certified Domestic Partner Child** – IRS indicates a domestic partner or partner's child can be considered a tax dependent if they meet certain criteria. The employee must

certify the Domestic Partner and/or Domestic Partner Child are a tax dependent. A tax dependent is treated as a legal dependent and is not subject to imputed income.

If an employee considers certifying his or her partner as a tax dependent, consulting a tax advisor is recommended. Falsely certifying a tax dependent may result in charges of tax fraud by the IRS and disciplinary action by the City.

DISCLAIMER: The foregoing examples are for illustration only and may not reflect your actual circumstances. The City of San Antonio and its Human Resources Department are not providing you with tax advice or legal advice. You are urged to consult your own tax advisor(s) concerning the federal income tax and employment tax ramifications from your enrolling your domestic partner or your partner's children in one of the City's sponsored plans.



CITY OF SAN ANTONIO

Human Resources Department

P. O. BOX 839966

SAN ANTONIO TEXAS 78283-3966

DOMESTIC PARTNERSHIP

Tax Dependent Status Form

I. INSTRUCTIONS

Before you enroll your domestic partner and/or domestic partner's child(ren) for health benefit coverage, be prepared to indicate whether your domestic partner and/or his or her child(ren) are your tax dependent(s) for federal income tax purposes. Use this form to indicate whether or not your domestic partner qualifies as your tax dependent under the Internal Revenue Code. Because the Human Resources Department cannot provide tax advice, seek help from your personal tax advisor if you have questions.

II. TAX DEPENDENT STATUS

If your domestic partner and/or his/her or child(ren) qualify as your tax dependent(s), as that term is defined by the Internal Revenue Code, then you may pay for your portion of health benefit premiums with pre-tax dollars. Furthermore, the portion of the premiums paid by the City of San Antonio will not be considered taxable income to you. Finally, you may also be able to utilize your flexible spending account for their health and /or dependent care expenses.

If your domestic partner and/or your domestic partner's child(ren) do not qualify as your tax dependent(s) for federal income tax purposes, then you must pay for their portion of health benefit premiums with after-tax dollars. Furthermore, the portion of the premiums paid by the City of San Antonio for coverage of your domestic partner and/or his or her child(ren) will be included in your gross income and subject to applicable payroll taxes. Finally, you will not be able to utilize your flexible spending account for their health and/or dependent care expenses.

If you fail to indicate the federal income tax status of your domestic partner and/or your domestic partner's children, the City of San Antonio will treat your domestic partner and/or domestic partner's children as not qualifying as your tax dependent(s) for federal income tax purposes.

III. TAX STATUS SELECTON

Please indicate on the reverse side of this form whether or not your domestic partner qualifies as your "dependent" for federal income tax purposes, as that term is defined under the Internal Revenue Code.

You should consult with your own personal tax advisor before you verify that your domestic partner and/or your domestic partner's child(ren) are dependents as defined by the Internal Revenue Code.



CITY OF SAN ANTONIO

Human Resources Department

P. O. BOX 839966

SAN ANTONIO TEXAS 78283-3966

Domestic Partner Tax Dependent Status

Check the box that applies.

Is your domestic partner your “dependent” as that term is defined by the Internal Revenue Code and its regulations and as that term is modified for purposes of coverage under accident or health plans under Internal Revenue Code?

☐ YES

☐ NO

Children of the Domestic Partner Tax Dependent Status

Is the child(ren) of your domestic partner, who you intend to cover, your “dependent(s)” as that term is defined by the Internal Revenue Code?

☐ YES

☐ NO

IV. SIGNATURE

I understand that the declarations I have made herein have legal and financial implications and that, before signing this document, I should seek advice from my personal tax advisor. I agree to reimburse the City of San Antonio for any and all liability including, but not limited to, taxes, penalties, or losses, that the City of San Antonio may incur due to its reliance on the statements I have made on this form. I agree to notify the City of San Antonio on the prescribed form, within thirty-one days, if there is any change in my domestic partner status which may make my domestic partner no longer eligible for benefits or if there is any change in the partner’s dependent status for federal income tax purposes.

Employee/Retiree Signature

Date

Domestic Partner Signature

Date

CITY OF SAN ANTONIO - 2013 Retiree Benefit Enrollment Form

INITIAL ENROLLMENT ☐

OPEN ENROLLMENT ☐

BENEFITS CHANGE ☐

SECTION 1 – RETIREE'S INFORMATION (must complete)

Name:		Social Security No.:	
Date of Birth:		Email:	
Phone Number(s):		Marital Status:	
Mailing Address:	APT #:	Single <input type="checkbox"/>	Married <input type="checkbox"/> Divorced <input type="checkbox"/>
City, State, Zip:			

Does the Retiree have both Parts A and B of Medicare? ☐ Yes ☐ No

Do any of the Retiree's dependents have both Parts A and B of Medicare? ☐ Yes ☐ No

If answer is yes, please specify dependent's name?

SECTION 2 – DEPENDENT(S) INFORMATION - Please complete for each Dependent(s) you wish to enroll in a COSA Health Plan.

First Name	Last Name	Birth Date	Social Security	Gender	Add/Drop Dependent
				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Drop
				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Drop
				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Drop

SECTION 3 – HEALTH PLAN OPTIONS

A. Coverage Level – Select coverage level

- | | |
|--|---|
| <input type="checkbox"/> Retiree Only | <input type="checkbox"/> Retiree + Two (2) or More Dependents |
| <input type="checkbox"/> Retiree + One (1) Dependent | <input type="checkbox"/> Opt Out (see reverse side) |

B. Retiree's Health Options – Select one only

Under Age 65-Non Medicare Only

- ☐ Consumer Choice
- ☐ Value PPO
- ☐ Standard PPO
- ☐ Premier PPO

Over Age 65 or Disabled-with Medicare Parts A & B

- ☐ Humana PPO
- ☐ Humana HMO
- Must complete Humana Enrollment Packet***

C. Dependent's Health Options – Select one only

Under Age 65-Non Medicare Only

- ☐ Consumer Choice
- ☐ Value PPO
- ☐ Standard PPO
- ☐ Premier PPO

Over Age 65 or Disabled-with Medicare Parts A & B

- ☐ Humana PPO
- ☐ Humana HMO
- Must complete Humana Enrollment Packet***

Section 4 – RECoSA (Select one only)

Retired Employees of the City of San Antonio (RECoSA) is an emerging, non-profit group of retired employees of the City of San Antonio focused on informing and communicating with fellow City retirees about changes in retirement benefits, health benefits and any other topics affecting retirees in the San Antonio area.

In an effort to provide you with the latest news and activity from RECoSA, the organization is requesting your address and e-mail address, if applicable. Below, please check the appropriate box.

☐ Yes, I would like to receive information from RECoSA. E-mail address: _____

☐ No thank you, I do not wish to receive information from RECoSA.

(complete reverse side)

TOBACCO USER CERTIFICATION

- Tobacco products include but are not limited to: cigarettes, cigars, pipes, all forms of smokeless tobacco (chewing tobacco, snuff, dip or any other product that contains tobacco), clove cigarettes or any other smoking devices that use tobacco such as hookahs. E-cigarettes which contain nicotine are also included.
- "Tobacco User" is defined by the City of San Antonio as a person who has used tobacco products within the past sixty (60) days.
- It is my obligation to submit an amended certification if I declare to be a Non-Tobacco User and become a Tobacco User, by resubmission of the required form through the Employee Benefits Division.
- **I understand that \$40 monthly fee is the surcharge amount that I will be obligated to pay if I acknowledge that I am a Tobacco User.**
- I understand that all surcharges as a Tobacco User will be prospective, and will not be refunded if I become a Non-Tobacco User. However, if I subsequently cease to be a Tobacco User, I may submit an amended certification changing my status from a Tobacco User to Non-Tobacco User. Once this amended certification is processed future surcharges will cease for the
- I understand that if I submit a certification changing from a Tobacco User to a Non-Tobacco User, I must also present a cert
- By making my election below, I acknowledge that I have read the above Tobacco User Certification information, understand

☐ I am **NOT** a tobacco user

☐ I am a tobacco user

WAIVER OF HEALTH COVERAGE

I understand that if I decline enrollment now and have no other health insurance coverage, I will be liable for any and all health care liabilities incurred due to this lapse in coverage.

Please provide name of other carrier and reason for opting out of coverage.

Carrier Name: _____

Opt-out Reason: _____

Retirees will have 31 calendar days from the loss of other coverage to notify the Human Resources Department to re-enroll in the City of San Antonio Retiree Medical Plan. If the change is not requested within 31 calendar days, your request to enroll cannot be made until the next open enrollment period.

ACKNOWLEDGEMENT

I have read the 2013 Benefits Guide explaining the City of San Antonio Benefits Program. I hereby make my election of benefits for 2013 and understand that my election cannot be changed once this form is received by the Employee Benefits Division. This change can be made at Human Resources within 31 calendar days of a loss of other coverage.

I swear or affirm that the information I have provided for the purpose of receiving health benefit coverage is true and accurate; and I understand that knowingly providing false information may result in loss of coverage, discipline, and criminal prosecution, if applicable.

Retiree Signature: _____

Date: _____

FOR CITY OF SAN ANTONIO USE ONLY
HUMAN RESOURCES - BENEFITS DIVISION

Retiree SAP#: _____

Customer #: _____

Sales Order #: _____

Years of Creditable Service: _____

Plan(s): _____

Premium Amount: \$ _____

\$ _____

CITY OF SAN ANTONIO - 2013 Benefit Enrollment Form

INITIAL ENROLLMENT ☐

OPEN ENROLLMENT ☐

BENEFITS CHANGE ☐

SECTION 1 – EMPLOYEE'S INFORMATION

Name:	Social Security No.:
Date of Birth:	SAP Number:
Daytime Phone Number(s):	

SECTION 2 – MEDICAL BENEFIT OPTIONS Plan & Coverage Level – Select level of coverage. DP = Domestic Partner

<input type="checkbox"/> Consumer Choice <input type="checkbox"/> Value PPO <input type="checkbox"/> Standard PPO <input type="checkbox"/> Premier PPO <input type="checkbox"/> Opt-Out Medical (see reverse side)	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse/DP <input type="checkbox"/> Employee + Child(ren)/DP Child(ren) <input type="checkbox"/> Employee + Child(ren)/DP Child(ren) + Spouse/DP
--	---

SECTION 3 – OTHER BENEFIT OPTIONS – Select level of coverage

<input type="checkbox"/> Delta Care DHMO (Delta Care form required) <input type="checkbox"/> CitiDent PPO (Delta Dental)	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse/DP <input type="checkbox"/> Employee + Child(ren)/DP Child(ren) <input type="checkbox"/> Employee + Child(ren)/DP Child(ren) + Spouse/DP
<input type="checkbox"/> Vision (Davis)	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse/DP <input type="checkbox"/> Employee + Child(ren)/DP Child(ren) <input type="checkbox"/> Employee + Child(ren)/DP Child(ren) + Spouse/DP
Dearborn National Additional Life Insurance (optional)	<div style="text-align: center;"> <input type="checkbox"/> None <input type="checkbox"/> 1X <input type="checkbox"/> 2X <input type="checkbox"/> 3X <input type="checkbox"/> 4X <input type="checkbox"/> 5X </div> <p style="color: red; text-align: center;">**As a new hire, Evidence of Insurability is required for Additional Life for 3X, 4X, or 5X annual base salary</p>
Dependent Life Insurance	<div style="text-align: center;"> <input type="checkbox"/> YES <input type="checkbox"/> NO </div>
ADDITIONAL LONG TERM DISABILITY (Increases from 40% to 60% of salary)	<div style="text-align: center;"> <input type="checkbox"/> YES <input type="checkbox"/> NO </div>
REIMBURSEMENT ACCOUNTS * Please provide the annual contribution amount. This amount will be divided by the remaining pay periods of the current year.*	Health Saving Account (HSA): \$ _____ (Consumer Choice Only) Health Care Flexible Spending Account (HFSA): \$ _____ Dependent Care Flexible Spending Account (DFSA): \$ _____

DEPENDENT PLAN COVERAGE Plan Codes: "M" For Medical "D" For Dental "V" For Vision

Relationship Codes: (1) Spouse (2) Dependent Child(ren) (3) Domestic Partner (4) Domestic Child(ren)

Please attach copies of all required validation documents for each dependent (i.e., marriage/birth certificate)

First Name	Last Name	Birth Date	Relation Code	Social Security	Gender	Plan	Add/Drop Dependent
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V	<input type="checkbox"/> Add <input type="checkbox"/> Drop
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V	<input type="checkbox"/> Add <input type="checkbox"/> Drop
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V	<input type="checkbox"/> Add <input type="checkbox"/> Drop
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V	<input type="checkbox"/> Add <input type="checkbox"/> Drop
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V	<input type="checkbox"/> Add <input type="checkbox"/> Drop

TOBACCO USER CERTIFICATION

• Tobacco products include but are not limited to: cigarettes, cigars, pipes, all forms of smokeless tobacco (chewing tobacco, snuff, dip or any other product that contains tobacco), clove cigarettes or any other smoking devices that use tobacco such as hookahs. E-cigarettes which contain nicotine are also included.

• "Tobacco User" is defined by the City of San Antonio as a person who has used tobacco products within the past sixty (60) days.

• It is my obligation to submit an amended certification if I declare to be a Non-Tobacco User and become a Tobacco User, by resubmission of the required form through the Employee Benefits Division.

• I understand that \$40 monthly fee is the surcharge amount that I will be obligated to pay if I acknowledge that I am a Tobacco User.

• I understand that all surcharges as a Tobacco User will be prospective, and will not be refunded if I become a Non-Tobacco User. However, if I subsequently cease to be a Tobacco User, I may submit an amended certification changing my status from a Tobacco User to Non-Tobacco User. Once this amended certification is processed future surcharges will cease for the duration of my Non-Tobacco user status.

• I understand that if I submit a certification changing from a Tobacco User to a Non-Tobacco User, I must also present a certificate of completion from a qualified Tobacco Cessation Program or medical physician.

• By making my election below, I acknowledge that I have read the above Tobacco User Certification information, understand it, and certify my election as accurate.

☐ I am **NOT** a tobacco user

☐ I am a tobacco user

WAIVER OF HEALTH COVERAGE

I understand that if I decline enrollment now and have no other health insurance coverage, I will be liable for any and all health care liabilities incurred due to this lapse in coverage.

Please provide name of other carrier and reason for opting out of coverage.

Carrier Name: _____

Opt-out Reason: _____

I understand that once an employee has waived coverage, no changes can be made during the year until the next annual open enrollment period, unless there is a legal change in family status.

If there is a legal change in family status, the employee may add or drop dependent coverage. A legal change in family status would allow the employee to change the coverage level of the medical, dental, and vision plans, and allow changes to their Health Care and/or Dependent Care Reimbursement accounts. Employees have 31 calendar days to notify the Human Resources Department to make the change. If the change is not requested within 31 calendar days of the legal change of status, the change cannot be made until the next open enrollment period. Legal documentation is required with any change request. A legal change in family status includes: divorce, marriage, death, birth or adoption of a child, change in employment status of the employee's spouse, or ineligibility of a child due to age.

ACKNOWLEDGEMENT

I have read the 2013 Benefits Guide explaining the City of San Antonio Benefits Program. I agree with the 2013 benefits selections and/or dependent information and authorize bi-weekly payroll deductions.

I swear or affirm that the information I have provided above for the purpose of receiving health benefit coverage is true and correct; and I understand that knowingly providing false information may result in loss of coverage, discipline, and criminal prosecution, if applicable.

☐ I agree with the 2013 benefits selections and/or dependent information and authorize bi-weekly payroll deduction in the amount of the reflected premium selected as well as a monthly \$40.00 tobacco surcharge if I am a tobacco user. Tobacco Surcharge is only applicable to employees certifying as tobacco users.

Employee Signature: _____

Date: _____

Office Use Only:

Processed

Pending

Other

Verified By

CITY OF SAN ANTONIO - 2013 Uniform Benefit Enrollment Form

INITIAL ENROLLMENT ☐

OPEN ENROLLMENT ☐

BENEFITS CHANGE ☐

SECTION 1 – EMPLOYEE'S INFORMATION

Please print, and complete all areas.

Name:		Social Security No.:
Date of Birth:		SAP Number:
Phone Number(s):		Email:
Mailing Address:	Apt #:	Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/>
City, State, Zip:		

SECTION 2 – In case of emergency, contact:

Name:	Phone:	Relationship:
-------	--------	---------------

SECTION 3 – MEDICAL BENEFIT OPTIONS

Select level of coverage and answer questions 1 and 2.

CitiMed Police Employee Only ☐ Employee +1 ☐ Employee +2 or more ☐

CitiMed Fire Employee Only ☐ Employee +1 ☐ Employee +2 or more ☐

☐ Opt-Out Medical (Attach required Opt-Out Form)

SECTION 4 – DEPENDENT PLAN COVERAGE Relation Codes: (1) Spouse (2) Dependent Daughter (3) Dependent Son (4) Domestic Partner (5) Domestic Child(ren)

First Name	Last Name	Birth Date	Relation Code	Social Security	Gender	Add/Drop Dependent
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Drop
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Drop
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Drop
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Drop
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Drop
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Drop

I have read the Collective Bargaining Agreement explaining the City of San Antonio Benefits Program. I hereby make my election of benefits for 2013 and understand that my election cannot be changed once this form is received by the Employee Benefits Division. This change may only be made in person at Human Resources within 31 days of a qualifying life event. (i.e., newborn, marriage, divorce, death, etc.)

I swear or affirm that the information I have provided above for the purpose of receiving health benefit coverage is true and correct; and I understand that knowingly providing false information may result in loss of coverage, discipline, and criminal prosecution.

Employee Signature: _____ Date: _____

Office Use Only: Process Pend Other Verified by